PATIENT REGISTRATION

TODAY'S DATE _____

PATIENT_____
FIRST NAME MIDDLE INITIAL LAST NAME PREFERRED NAME

PHONE NUMBERS: **HOME**_____ **CELL PHONE** _____

IN CASE WE MAY NEED TO CONTACT YOU FOR MORE INFORMATION, WHICH WAY IS THE BEST WAY TO DO SO?
HOME PHONE__ MOBILE PHONE__ EMAIL__

MAY WE LEAVE A MESSAGE? ☐/☐

STREET ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

EMAIL_____ SEX: ___MALE ___FEMALE

BIRTHDATE_____ MARITAL STATUS _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT_____ BIRTHDATE_____

EMPLOYER_____ EMPLOYER PHONE #_____

EMPLOYERS ADDRESS_____

SPOUSE NAME_____ BIRTHDATE_____

SPOUSE EMPLOYER_____ EMPLOYER PHONE #_____

PRIMARY DENTAL INSURANCE COMPANY: _____

ID#_____ GROUP#_____

SECONDARY DENTAL INSURANCE COMPANY: _____

ID#_____ GROUP#_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ PHONE#_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

I ASSIGN DIRECTLY TO SOUTHLAND SMILES, LTD ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED, FOR PAYING ANY CO-PAYMENT, DEDUCTIBLES AND ANY COLLECTION FEES INCURRED TO SECURE PAYMENT ON MY ACCOUNT. I HEREBY AUTHORIZE SOUTHLAND SMILES, LTD TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

_____ _____
DATE SIGNATURE

HEALTH HISTORY

PATIENT'S NAME TODAY'S DATE

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ☐ ☐
2. Has there been any change in your general health in the past year? ☐ ☐
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ☐ ☐
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ☐ ☐

   _____

   _____

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ☐ ☐
   - B. Congenital Heart Disease? ☐ ☐
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ☐ ☐
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ☐ ☐
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ☐ ☐
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ☐ ☐
   - G. Liver Disease (Jaundice, Hepatitis)? ☐ ☐
   - H. Kidney Disease? ☐ ☐
   - I. Diabetes? ☐ ☐
   - J. Thyroid Disease (Goiter)? ☐ ☐
   - K. Arthritis? ☐ ☐
   - L. Stomach Ulcers or Colitis? ☐ ☐
   - M. Glaucoma? ☐ ☐
   - N. Implants placed in your body (Heart Valve, Pacemaker, Hip, Knee)? ☐ ☐
   - O. Radiation (X-ray) treatment for Cancer? ☐ ☐
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ☐ ☐
   - Q. Sinus or Nasal problems? ☐ ☐
   - R. Any disease, drug or transplant operation that has depressed your immune system? ☐ ☐
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ☐ ☐
   - B. Anticoagulants (Blood Thinners)? ☐ ☐
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ☐ ☐
   - D. High Blood Pressure medications? ☐ ☐
   - E. Steroids (Cortisone, etc.)? ☐ ☐
   - F. Tranquilizers? ☐ ☐
   - G. Insulin or Oral Anti-Diabetic drugs? ☐ ☐
   - H. Digitalis, Inderal, Nitroglycerin or other heart Drug? ☐ ☐
   - I. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

     _____

     _____
   - J. Are you taking or have you taken Bisphosphonate or any other medication to treat osteoporosis, osteopenia, multiple myeloma or malignancy? If so please describe……Y/N _____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ☐ ☐
   - B. Penicillin or other antibiotics? ☐ ☐
   - C. Sedatives, Barbiturates? ☐ ☐
   - D. Aspirin or Ibuprofen? ☐ ☐
   - E. Codeine or other pain killers? ☐ ☐
   - F. Latex or Rubber Products? ☐ ☐
   - G. Other allergies or reactions? Please, list ☐ ☐

     _____

     _____
10. Do you smoke or chew Tobacco? ☐ ☐
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ☐ ☐
12. Have you had any serious problems associated with any previous dental treatment? ☐ ☐
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ☐ ☐
14. Do you wish to talk to the doctor privately about anything? ☐ ☐
15. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ☐ ☐
    - B. Are you nursing? ☐ ☐
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I AFFIRM THAT THE INFORMATION GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

DATE SIGNATURE

Southland Smiles
19815 Governors Hwy Suite #7 info@southlandsmiles.com
Flossmoor, IL 60422 708-799-7800

Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- Conference presentations
- Educational presentations or courses
- Informational presentations
- On-time educational courses
- Educational Videos

By signing this release, I understand this permission signifies that photographic of video recordings of me may be electronically displayed via the internet or in the public educational settings.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio, or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to the bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name _____
Street Address/ P.O. Box _____
City _____ State/ Zip_____
Phone_____ Fax _____
Email Address _____

Signature_____ Date _____

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.
Parent's Signature_____ Date_____-

Southland Smiles
19815 Governors Hwy Suite #7 info@southlandsmiles.com
Flossmoor, IL 60422 708-799-7800

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____
Patient Name Date

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPAA), I have certain Patient Rights regarding my protected health information.

I understand that Southland Smiles may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Southland Smiles has a detailed document called the *'Notice of Privacy Practices'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '*Notice*' before signing this agreement. If I ask, Southland smiles will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Southland Smiles to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Southland Smiles has taken action relying on this consent

_____ _____
SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____
Relationship to Patient if Signed by another party **DATE**

You may obtain a copy of our Notice of Privacy practices, including any revisions of our 'Notice' at any time by contacting: Southland smiles, 19815 governors Hwy Suite 7, Flossmoor, IL 60422, 708-799-7800.